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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-OTIS STREET HOME	**2415 OTIS STREET DURHAM, NC 27707**

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W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to provide hair care and grooming services to 1 of 4 audit clients (#2). The finding is: During observations of client #2 from 8/19/24 to 8/20/24, the client had a scruffy appearance with untrimmed hair and considerable facial hair on cheeks and underneath chin. Record review on 8/20/24 of client #1's Community-Life Assessment completed on 5/27/24 revealed a visual impairment, with verbal cues needed to go to the barber as well as physical assistance to shave. Interview on 8/20/24 with the Site Supervisor (SS) revealed they took the clients to the barber college three weeks ago, but the stylist who cuts their hair and trims facial hair was off. The SS revealed she had to wait for an upcoming appointment, since this was the only location where the clients could receive a budget haircut for both grooming needs. Interview on 8/20/24 with the Program Director (PD) confirmed that clients are allocated a free hair cut with grooming once a month through their Medicaid funds. The PD revealed the facility loads money on a P-Card to pay for monthly haircuts that the SS has authorization to use.	W 125		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 217	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure an annual nutritional evaluation was performed for 1 of 4 audit clients (#3). The finding is: Record review on 8/19/24 of client #3's annual assessments, revealed there was no evidence her nutritional status was reviewed and updated by a registered dietician. Interview on 8/20/24 with the Program Director revealed she could not find any document that a nutritional evaluation was completed for client #3 since May 2023.	W 217		
W 325	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(iii) The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to perform routine laboratory examinations for 1 of 4 audit clients (#4) with epilepsy. The finding is: Record review on 8/19/24 of client #4's laboratory records from 5/1/23 revealed Valproic Acid level at 107, slightly elevated. An additional review of an Aftercare Discharge Summary revealed on 1/17/24, client #4 was seen at the emergency room for seizures and had his seizure medication	W 325		

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W 325	Continued From page 2	W 325		

changed. The doctor wrote a new order to discontinue Keppra and increased the dose of Divalproex from 250mg to 500mg at 7:00am for client #4, until 2/21/24.

Record review on 8/20/24 of the Medication Administration Record (MAR) for January-February, 2024 for client #4 revealed client #4 still received the 250mg dose of Divalproex at 7:00am on 1/18, 1/21, 1/23, 1/28, 2/1, 2/7, 2/9, 2/12, 2/15, 2/16, 2/19-2/23, 2/26-2/29. In addition, client #4 also received an additional 500mg dose of Divalproex at 7:00am, 2/1/24 through 2/21/24. Client #4 missed the 5:00pm dose of Divalproex 500mg on 1/21, 1/22, 1/25-1/31 and 2/18.

Record review on 8/20/24 revealed an Aftercare Discharge Summary 5/13/24 that revealed client #4 was hospitalized from 5/9/24 to 5/13/24, for seizures. It was concluded the seizures were due to missed medications and dehydration; client #4 would follow-up with neurologist in July, 2024. There were no records of laboratory results for May, 2024. An additional review of the Neurology Consult revealed on 7/29/24, client #4 was seen and his the Valproic Acid was at 65, within the therapeutic range. There were no new orders to routinely check client #4's anti-seizure medications after two related hospitalizations.

Review on 8/20/24 of Medscape.com's 11/20/19 article on Valproic Acid Levels reveal "Generally, the dosage is considered optimal if the valproic acid level is within the therapeutic range and the patient is receiving treatment benefits (eg. suppression of seizures) without adverse effects. Valproic acid levels should be obtained on patients taking this medication regularly for

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W 325	Continued From page 3 medical treatment and should also be considered in addition to standard toxicology panels when ingestion or overdose of valproic acid is suspected...Monitoring of serial valproic acid levels is required to maintain the drug within the narrow recommended therapeutic range. Subtherapeutic levels place the patient at risk of recurrence of the condition for which they are taking valproic acid, and supratherapeutic levels place the patient at risk of adverse and toxic side effects. Dosages of valproic acid must be adjusted carefully based on valproic acid blood levels until a steady drug concentration is ensured within the therapeutic range." Interview on 8/20/24 with the Site Supervisor (SS) and qualified intellectual disabilities professional (QIDP) revealed they were unaware client #4's two hospitalizations were the result of not getting the correct dosage of anti-seizure medications and the absence of laboratory monitoring. Interview on 8/20/24 with the Program Director (PD) revealed she could not find any routine orders to draw laboratory tests for clients since 2022, on their Physician's Orders. The PD did not indicate the frequency needed to monitor valproic acid levels.	W 325		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure nursing services to monitor 1 of 4 audit clients (#4) medical aftercare treatment for a seizure disorder, to ensure that	W 331		

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out of stock seizure medications were re-ordered in a timely manner. The finding is:

Record review on 8/19/24 of an Aftercare Discharge Summary revealed on 1/17/24, client #4 was seen at the emergency room for seizures and received a new order to increase the Divalproex from 250mg to 500mg at 7:00am until 2/21/24.

Record review on 8/20/24 of the Medication Administration Record (MAR) for January-February, 2024 for client #4 revealed client #4 missed 12 doses of seizure medications, due to out of stock.

Record review on 8/20/24 revealed an Aftercare Discharge Summary on 5/13/24 revealed from 5/9/24 to 5/13/24, client #4 was hospitalized for seizures. The report referenced under comments client #4's seizures were due to missed medications and dehydration. The last laboratory results for valproic acid that the facility had in client #4's record was from May, 2023. An additional review of the Neurology Consult revealed on 7/29/24, client #4 was seen and his the Valproic Acid was at 65, within the therapeutic range.

Interview on 8/20/24 with the Site Supervisor (SS) revealed the facility has not had a nurse for most of the year and had to rely on an on-call nurse system to triage new medical concerns. The SS revealed the facility had a nurse this Spring, but the nurse quit a month ago.

Interview on 8/20/24 with the Program Director confirmed the facility has not had a nurse visiting the home most of the year.

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W 347	NURSING STAFF CFR(s): 483.460(d)(5) Non-licensed nursing personnel who work with clients under a medical care plan must do so under the supervision of licensed persons. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure medication technicians were supervised by a licensed nurse; to monitor their demonstration of medication administration procedure; the proper manner to dispose of medications and to ensure the timely refill of medications. This affected 2 of 4 of the audit clients (#4 and #6). The findings are: A. During morning medications in the home on 8/20/24 at 6:30am, Staff D gave client #6 his Benztropine and Gabapentin medications. Client #6 ingested the medications, without incident. Record review on 8/20/24 of Physician's Orders dated 7/3/24 for client #6 revealed The Benztropine and Gabapentin should be given at 8:00am. Interview on 8/20/24 with Staff D revealed she can pass medications an hour before or later from the prescribed dose time. Interview on 8/20/24 with the Site Supervisor (SS) revealed giving client #6 the Benztropine and Gabapentin 90 minutes before 8:00am was too early. B. During evening medications in the home on 8/19/24 at 4:42pm, Staff D was administering medications to client #6 when a loose pill in the medication bin was observed.	W 347		

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Interview on 8/19/24 with Staff D revealed the loose pill was a calcium pill for client #6 and she speculated that one of the doses was missed, possibly from 8/3/24. Staff D revealed she was going to call and report it.

Interview on 8/20/24 with the SS revealed she was contacted by Staff D about the loose calcium pill and the triage nurse was contacted and gave instructions on disposing the pill. The SS revealed the doctor was contacted to write an order to have pharmacy replace the pill.

C. Record review on 8/19/24 of client #4's Aftercare Discharge Summary from 1/17/24 revealed a new order was written to increase his seizure medication. The Medication Administration Record (MAR) for January-February, 2024 for client #4 revealed client #4 still received the 250mg dose of Divalproex at 7:00am on 1/18, 1/21, 1/23, 1/28, 1/28, 2/1, 2/7, 2/9, 2/12, 2/15, 2/16, 2/19-2/23, 2/26-2/29. Client #4 also received the correct 500mg dose of Divalproex at 7:00am 2/1-2/21. Client #4 did not get the 5:00pm dose of Divalproex 500mg on 1/21, 1/22, 1/25-1/31 and 2/18. The MAR revealed the triage nurse was not contacted to assist with securing the proper dosage of seizure medication for client #4.

Interview on 8/20/24 with the Site Supervisor (SS) and qualified intellectual disabilities professional (QIDP) revealed the facility did not have a nurse coming to the home. The SS and the QIDP were unaware client #4's two hospitalizations in 2024 were the result of not getting the correct dosage of anti-seizure medications. In addition, the SS revealed that medications could have been re-ordered by the medication technicians.

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W 347	Continued From page 7 Interview on 8/20/24 with the Program Director revealed the medication technicians should have re-ordered the out of stock medications directly from the electronic MAR (QMAR). The Program Director also confirmed the facility did not currently have a licensed nursing coming to the home and they relied on an on-call triage nurse service for months.	W 347		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to administer medications for 1 of 4 audit clients (#6) as prescribed by the physician. The finding is: During morning observations of medications in the home on 8/20/24 at 6:35am, Staff D gave Benztropine and Gabapentin to client #6 to consume with his multi-vitamin and Fanapt. Record review on 8/20/24 revealed Physician's Orders for client #6 dated 7/3/24. Client #6 should receive Benztropine and Gabapentin at 8:00am. Interview on 8/20/24 with Staff D revealed she had the option to give the medication an hour before or after the prescribed time. Interview on 8/20/24 with the Site Supervisor (SS) acknowledged staff trained to give medications can give medications an hour before or after the prescribed time. The SS confirmed if the orders	W 368		

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W 368	Continued From page 8 were for 8:00am, it was too early for client #6 to receive two of his medications at 6:30am.	W 368		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to provide knives to cut up meats at meals for 1 of 4 audit clients (#4). The finding is: During dinner observations in the home at 5:40pm, client #4 was served a piece of baked boneless barbecue chicken, potato salad and green beans for dinner. Client #4 only had a fork for his utensil. Client #4 was observed on multiple occasions to pick up the chicken with his hand and bite off pieces of meat until it was consumed. There were no prompts by staff to get a knife to cut up the chicken. Record review on 8/20/24 of client #4's Community-Life Assessment from 6/6/24 revealed he was independent eating with a knife and might need redirecting to use utensils appropriately. Interview on 8/20/24 with the Site Supervisor (SS) revealed client #4 should have received a knife at dinner to enable him to cut up his meat.	W 475		